Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: ALANI, WAYNE O 7401 S. MAIN STREET HOUSTON, TX 77030-4509	MFDR Tracking #: M4-10-4335-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Carrier's Austin Representative Box #: HOUSTON ISD Box #: 21	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

The requestor did not submit a position statement in accordance with rule §133.307. The following is taken from the DWC-60 table of disputed services: "Not paid according to fee guidles {sic}"

Amount in Dispute: $248.66

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is seeking reimbursement for date of service August 7, 2009 in the amount of $248.66. The table of disputed services indicates that the provider has only been reimbursed $974.32 for the date of service at issue. The Carrier initially paid $974.32 in this matter and upon reconsideration paid an additional $169.39 in this matter. The Carrier has paid a total of $1143.71 in this matter for that date of service at issue. The services were reimbursed in accordance with Medical Fee Guidelines and no further reimbursement is due."

Response Submitted by: Thornton Law Firm, 912 S. Cap. Of Tx. Hwy., Suite 300, Austin, TX 78746

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
8/7/09	29880-LT	67.38 ÷ 36.0666 x $654.63 = $1,222.99	$248.66	$248.66
			Total Due:	

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 12/18/2009
   - W1 – Workers compensation state fee schedule adjustment

   Explanation of benefits dated 5/18/2010
   - W1 – Workers compensation state fee schedule adjustment
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Did the insurance carrier reimburse the requestor per the medical fee guidelines for the disputed services?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor listed CPT code 29880-LT (arthroscopy, knee, surgical with meniscectomy (medial AND lateral, including any meniscal shaving) (left side) for date of service 8/7/09 as the disputed code. The insurance carrier paid $974.32 for this disputed service and the requestor is seeking additional reimbursement. The respondent states in their position statement that an additional $169.39 was paid on reconsideration. The respondent submitted an EOB dated 5/18/2010 which is the same EOB that the requestor submitted supporting payment of $169.39. However, this payment is for HCPCS code G0289 which is not in dispute. The MAR amount for CPT code 29880-LT is $1,222.99. Therefore, additional reimbursement to the requestor is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $248.66.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $248.66 plus applicable accrued interest per Division rule at 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**6/29/11** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.